This form may be completed online, printed and mailed to the address listed.

Health and Human Services Regulation and Licensure
Credentialing Division, PO Box 94986
Lincoln NE 68509
402/471-4376 or fax 402/471-1066

NURSE MIDWIFE PRACTICE AGREEMENT

Between:

Name_____ Phone (H) _____

Address_____ (W) _____

_____ R.N. License No._____

Hereinafter referred to as a Nurse Midwife and legally defined as a Certified Nurse Midwife (CNM) who meets the requirements as defined in Neb Rev Stat 71-1748 and who holds a current license as a CNM issued by the Department

and the collaborating physician(s) named below:

Physician Name_____ Physician Name_____

Address_____ Address _____

License #_____Specialty_____ License #_____ Specialty_____

Physician Name_____ Physician Name_____

Address_____ Address_____

License # _____Specialty_____ License#_____Specialty_____

Hereinafter referred to as physician(s) and legally defined as a Nebraska licensed physician whose practice includes obstetrics.

at the practice sites identified below:

Office:_____ Office:_____

Address_____ Address_____

Hospital:_____ Hospital:_____

Address_____ Address_____

Public Health Agency _____ Public Health Agency _____

Address _____ Address _____

Whereas, the parties have developed this practice agreement provided for under Nebraska Revised Statutes, Chapter 71-1750 and 71-1753; and

Now therefore, it is agreed by and between the physician(s) and the nurse midwife hereto:

1. This agreement shall not take effect until it has been completely executed and a copy with notarized signatures has been filed in the office of the Department of Health & Human Services Regulation and Licensure, and a copy of which along with an authority letter has been returned to the nurse midwife and available at the work site; and
2. This agreement shall be continuous so long as conditions remain as agreed between parties on date of execution. Any change in terms of this agreement renders this practice agreement void. Any change in terms of practice agreement requires that an amendment to the agreement be filed with the Department of Health & Human Services Regulation and Licensure and approval granted by the Boards and authorized through an authority letter prior to the change taking effect. The CNM and collaborating physician have a duty to notify the Department of the termination of this agreement.
3. The collaborating physician(s) shall be responsible for supervision through ready availability for consultation and direction to the CNM when any delegated medical functions are provided by the CNM; and
4. The CNM and collaborating physician shall have jointly approved protocols for all delegated medical functions which shall guide the CNM's practice. The protocols shall be reviewed, updated, and reaffirmed by both parties on a regular basis and no less frequently than every two (2) years. Protocols must be available at all work sites; and
5. The specific medical functions delegated to the nurse midwife shall be based upon the educational preparation and continued experience of the nurse midwife. Validation, including documentation, of education/training and assessment of competency shall be the responsibility of the nurse midwife and the physician. Specific medical functions may include:
   (a) attending cases of normal childbirth;
   (b) providing prenatal, intrapartum, and postpartum care;
   (c) providing normal obstetrical and gynecological services for women;
   (d) providing care for the newborn immediately following birth; and
   (e) prescribing legend drugs, Schedule II controlled substances for up to 72 hours and for pain control, and Schedule III, IV, and V controlled substances.
6. As an RN, a Certified Nurse Midwife may assist with cesarean sections.

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STATE OF_____ COUNTY OF_____

I, _____ being duly sworn, say that I am the person referred to in this Practice Agreement as a nurse practitioner in the State of Nebraska; that the statements herein contained are true to the best of my knowledge and belief; and that I have read and understand the affidavit.

Signature Nurse Midwife_____

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STATE OF _____ COUNTY OF_____

I, _____ being duly sworn, say that I am the person referred to in this Practice Agreement as a physician in the State of Nebraska; that the statements herein contained are true to the best of my knowledge and belief; and that I have read and understand the affidavit.

Signature Physician_____

STATE OF ________________________________ COUNTY OF_______________________________________

I, ____ being duly sworn, say that I am the person referred to in this Practice Agreement as a physician in the State of Nebraska; that the statements herein contained are true to the best of my knowledge and belief; and that I have read and understand the affidavit.

Signature Physician____

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STATE OF ________________________________ COUNTY OF_______________________________________

I, ____ being duly sworn, say that I am the person referred to in this Practice Agreement as a physician in the State of Nebraska; that the statements herein contained are true to the best of my knowledge and belief; and that I have read and understand the affidavit.

Signature Physician____

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STATE OF ________________________________ COUNTY OF_______________________________________

I, ____ being duly sworn, say that I am the person referred to in this Practice Agreement as a physician in the State of Nebraska; that the statements herein contained are true to the best of my knowledge and belief; and that I have read and understand the affidavit.

Signature Physician____

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STATE OF ________________________________ COUNTY OF_______________________________________

I, ____ being duly sworn, say that I am the person referred to in this Practice Agreement as a physician in the State of Nebraska; that the statements herein contained are true to the best of my knowledge and belief; and that I have read and understand the affidavit.

Signature Physician____